

Acupuncture and Chiropractic Center

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Case

Patient information

PATIENT NAME:

Last: _____ First: _____ Middle _____

Home Address _____ Apt.# _____

City _____ State _____ Zip _____

Email address _____

Home Phone: _____ Cell Phone _____ Work Phone _____

Gender: M F Date of Birth ___/___/___ Age ___ Marital Status (Circle One): S M W D Sep

Employer _____ Occupation _____

Employer Address _____ STE.# _____

City _____ State _____ Zip _____

SPOUSE OR GUARDIAN

Last Name _____ First Name _____ Middle _____

Date of Birth ___/___/___ Employer: _____ Phone: _____

EMERGENCY Name and address of nearest relative or friend not living with you.

Last name _____ First Name _____ Middle _____

Phone # _____ Work phone # _____ Relationship to Patient _____

How did you find out about our office? _____

PAYMENT METHODS ACCEPTED

Cash Check Visa Mastercard Discover

MY CERTIFICATION

I certify that the above information is correct and I request services

X _____ Date _____
Signature of patient or person acting on the patients behalf

- I have read a copy of the **Notice of Privacy Practices**. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directing and indirectly involved in providing my treatment.

- I have read the Notice of Privacy Practices and do not understand. I require more information

X _____ Date _____
Signature of patient or person acting on the patients behalf

Name _____ Age _____ Height _____ Weight _____ RH LH

Indicate services you are interested in: _____ Chiropractic _____ Acupuncture

Are you expecting: _____ Temporary Relief _____ Permanent Relief

WHAT IS IT THAT YOU WANT HELP WITH. What would you like to address:

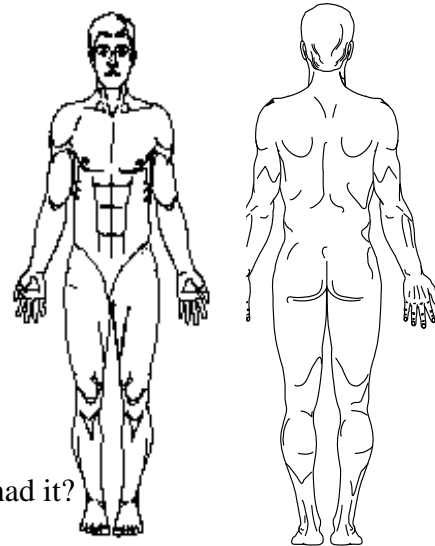
Are there any secondary problems you would eventually like to discuss?

Please indicate the location of your pain

Please tell me where you are having the pain and what it feels like to you.

What is the level of your pain?

Mild	1	2	3	
Moderate	4	5	6	7
Severe	8	9	10	



HOW and WHEN did your pain begin?

Is this the **FIRST** time you have ever had this type of pain. YES NO

If you have had this same type of **PAIN BEFORE**, when was the first time you had it?

Is this the worse episode you have had? YES NO

Have you ever had treatment for this condition? YES NO

For this episode of pain: Since it started is it:

Staying the same Getting worse Getting better

What **activity or thing** makes your pain worse?

Is there anything that makes it feel better.

Have you had any other doctors treat you for this condition? What type of treatments have you had?

MEDICAL TREATMENT:

YES NO DR. _____ Last Visit _____

What type of treatment have you received?

CHIROPRACTIC TREATMENT:

YES NO DR. _____ Last Visit _____

What type of treatment have you received?

OTHER TREATMENT

Explain what you are doing at home to relieve your pain. (Ex. Heat, Ice, Medications, Rest) Please Explain.

PAST MEDICAL HISTORY:

SURGERY/OPERATIONS:

List your Surgeries if you have had any.

1) _____ 2) _____

List any previous accidents or traumas you may have had.

Date _____ Date _____

Date _____ Date _____

DIAGNOSTIC TESTING: (Because of your immediate problem have you ever had x-rays or other tests taken.

MEDICATIONS: Please list ALL medications you are taking: This includes vitamins or other remedies you may be taking.

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

ALLERGIES: Are you allergic to any medications?

Family Physician? _____. Do you see him for any conditions? What?

Indicate any problems with:

Skin or Hair _____

Head Eyes, Ears, Nose, or Throat: _____

Heart: _____

Lungs, Sinus, Cough: _____

Stomach \ Intestinal: _____

Genito-Urinary: _____

Reproductive / Gynecological: _____

Neuropsychological: _____

Sign _____ SS# - - Date / /

Thanks for filling this out as accurately as you can about your health, because it could save you some time.

□ Robert F. Cowan DC, CAP

Informed Consent For The Chiropractic Adjustment

Patient: _____

Date: _____

The primary treatment used by doctors of chiropractic is the spinal adjustment. I will use that procedure to treat you.

- The nature of the Chiropractic Adjustment:
I will use my hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles. You may feel or sense movement.
 - The material risks inherent in chiropractic adjustment:
As with any health care procedure, there are certain complications, which may arise out of or during a chiropractic adjustment. Those complications include: fractures, disk injuries, dislocations or sprains of the vertebrae or ribs and muscle strain. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.
 - The probability of those risks occurring:
Depending on what authority you wish to believe, the percentages vary greatly. Most of these risks are remote but they still exist.
 - Do you have any questions about the risks of chiropractic adjustments?
____ No ____ Yes _____ Initials
- If yes, what is/are the question (s)
- Ancillary treatment:
In addition to chiropractic adjustments, I may use one of the following treatments:

Electrical stimulation	Therapeutic exercise	Myofascial Release
Ultrasound	Vibration	Hot /Cold Packs

These treatments involve the following additional risks:

-
- The availability and nature of other treatment options:
Self Treatment
Medical Treatment
 - Since all possible problems could not possibly be covered and evaluated by your initial reason for coming to this office would you like to be referred to another doctor before you make a decision for treatment.
____ No ____ Yes _____ Initials

Do not sign until you have read and understand the above.

Please check the appropriate block and sign below

I have read I have not read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the above named Doctor and have had my questions answered to my satisfaction. Having no further questions and with an understanding of the potential risks and benefits of care in this clinic. I choose to have care started as recommended.

Dated _____ Patient Name _____

Please Print

Signature (Signature of Guardian if Minor)

ACUPUNCTURE
PATIENT QUESTIONNAIRE AND INFORMED CONSENT FORM

- | | | |
|--|-----|----|
| 1. Are you now or have you recently been on any medications?
If the answer to #1 is yes, what are they? | Yes | No |
| <hr/> | | |
| 2. Are you now, or have you ever been on blood thinners or anticoagulants? | Yes | No |
| 3. Have you ever taken cortisone or other drugs for arthritis? | Yes | No |
| 4. Do you bleed easily? | Yes | No |
| 5. Have you ever been told you have a heart problem? | Yes | No |
| 6. Do you have a pacemaker or another device that has been surgically implanted in your body? | Yes | No |
| 7. Have you ever had hepatitis or has your skin ever turned yellow in color? | Yes | No |
| 8. Have you ever had a venereal disease or been in contact with AIDS? | Yes | No |
| 9. Have you ever received a blood transfusion?
If so, when? _____ How many units? _____ | Yes | No |
| 10. Do you faint easily? | Yes | No |
| 11. Have you ever used drugs: i.e Heroin, Cocaine, etc? | Yes | No |

Meridian Therapy (Acupuncture) is an Oriental procedure that is still being researched and investigated in this country. Please read the following statements that relate to this procedure; this is to comply with guidelines formulated by the FDA. (If you cannot read, they will be read to you for your consideration.)

1. I, the undersigned, hereby authorize and direct Dr. Robert F. Cowan and associates to administer acupuncture, which involves the insertion of needles or staples at one or more points in the body, or the application of other Oriental forms of Meridian Therapy he may feel necessary at the time.
2. I understand that any and all questions posed by me regarding the acupuncture procedure to be used will be answered by Dr. Cowan or his assistants prior to receiving my initial treatment.
3. I understand that the exam and treatment may require that I partially disrobe and that if, for any reason I wish to have an assistant present during any part of the exam, I will be free to ask for one.
4. I understand that in no manner have I been warranted or guaranteed a beneficial result from treatment by acupuncture.

I have read the above statements, and I consent to the use of acupuncture and realize that it is not the standard treatment in the community and other forms of treatment may be available for my condition.

DATE _____

Patient's Signature _____